Rukobia (fostemsavir)

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED PROVIDER LETTER TO 855-828-4992

Criteria for Approval (at least one of the following criteria must be met):

- ❑ 18 years of age or older.
- ❑ Prescribed by or in consultation with an infectious disease specialist.
- ❑ Trial and failure of, resistance, intolerance, or contraindication to at least 4 antiretroviral therapies, including:

Medication/Dose	Details of Failure	Chart Note Page #
Nucleoside Reverse-Transcriptase Inhibitor (NRTI) Medication:		
Non-Nucleoside Reverse-Transcriptase Inhibitor (NNRTI) Medication:		
Protease inhibitor Medication:		
C-C Chemokine Receptor type 5 (CCR5) antagonist Medication:		
Fusion inhibitor Medication:		

- ❑ Rukobia will be used concomitantly with other antiretroviral(s) indicated for the treatment of HIV-1 infection. Medication(s): _____ Chart note page #: _____
- ❑ Patient is NOT taking CYP3A inducers concomitantly, which may significantly reduce fostemsavir plasma concentration, resulting in a loss of virologic response. These drugs include, but are not limited to:
  - Androgen receptor inhibitor: enzalutamide
  - Anticonvulsants: carbamazepine, phenytoin
  - Antimycobacterial: rifampin
  - Antineoplastic: mitotane
  - Herbal product: St John's wort (Hypericum perforatum)

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating maintenance of virological suppression with HIV-1 RNA less than 50 copies/mL.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date